**Calendar No. 272**

106TH CONGRESS, *1st Session* | SENATE | REPORT 106–152

# AMENDING THE INDIAN HEALTH CARE IMPROVEMENT ACT TO MAKE PERMANENT THE DEMONSTRATION PROGRAM THAT ALLOWS FOR DIRECT BILLING OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS, AND TO EXPAND THE ELIGIBILITY UNDER SUCH PROGRAM TO OTHER TRIBES AND TRIBAL ORGANIZATIONS

SEPTEMBER 8, 1999.—Ordered to be printed

Mr. CAMPBELL, from the Committee on Indian Affairs, submitted the following

## REPORT

[To accompany S. 406]

The Committee on Indian Affairs, to which was referred the bill (S. 406) to amend the Indian Health Care Improvement Act to make permanent the demonstration program that allows for direct billing of medicare, medicaid, and other third party payors, and to expand the eligibility under such program to other tribes and tribal organizations, having considered the same, reports favorably thereon with an amendment in the nature of a substitute, and recommends that the bill (as amended) to pass.

### PURPOSE

The purpose of S. 406 is to make permanent a direct billing demonstration program authorized by the Indian Health Care Improvement Act Amendments of 1988, Pub. L. 100–713. The bill makes the program permanent for the four demonstration programs and expands the eligibility to other tribes and tribal organizations which operate IHS hospitals and clinics. It provides that all funds received through the program be used specifically to maintain accreditation or, if that has been secured, to address the lack of health resources available to that tribe. The bill recognizes the success of the demonstration program, and that the program enhances and reinforces the ideas contained in the Indian Self-Determination

and Assistance Act (Pub. L. 93–638, 25 U.S.C. 450 et seq.) to strengthen the government-to-government relationship between tribes and the Federal government.

## BACKGROUND

In exchange for the cession of millions of acres of land to which Indian tribes held aboriginal title, the United States entered into treaties with Indian nations. Many of the treaties provided that health care services would be guaranteed to the citizens of Indian country in perpetuity.

The Federal obligation for the provision of health care services in Indian country also arises out of the special trust relationship between the United States and Indian tribes, as reflected in Article I, Section 8, Clause 3 of the U.S. Constitution, which has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders.

The first Federal statute authorizing the appropriation of Federal funds to carry out the United States' trust and treaty responsibilities was the Snyder Act of 1921, 25 U.S.C. 13. In 1976, the Indian Health Care Improvement Act ("IHCIA") became law. The IHCIA was the first comprehensive statute specifically addressing the provision of health care in Indian country and the Federal administration of health care of Native Americans. In 1988, amendments to the IHCIA provided for the creation of a Medicare and Medicaid direct billing demonstration program which is made permanent by this legislation.

### A. THE IHS AND BILLING PRACTICES

Prior to 1988, tribes who operated IHS hospitals and clinics submitted their requests for reimbursement for Medicare and Medicaid outlays or expenditures to the Indian Health Service. The submission of that request began a complex, arduous process which did not always result in payment.

Once a patient was seen by the IHS facility, a claim was generated and sent to the Indian Health Service Area Office. The Area Office, in turn, made a claim to the Fiscal Intermediary (the agent responsible for processing Medicare and Medicaid claims (oftentimes a state) responsible for payment of the claim.

Once the Fiscal Intermediary paid the IHS Area Office, the funds were deposited in the Federal reserve and sent to the Department of the Treasury, where payment was apportioned back to the IHS Headquarters. The Area Office would then request funds from IHS Headquarters, and once the amount an Area Office would receive was determined, the Area Office would modify the Tribe's "638" contract to reflect the actual amount received from IHS Headquarters and which was to be paid to the tribe.

When the payment was received by the tribe operating IHS facility, it was always difficult, if not impossible, for the tribe to determine which of the submitted claims had been paid and which had been denied, as there was no list provided which identified claim numbers to the tribe. Oftentimes, according to tribal officials, if a payment register was received, it would not be for months or years after the original claim was made and no attempt could be made

to resubmit the claim. Officials reported periods as long as two years between submission of a claim and reimbursement or denial of the claim.

Tribal officials also claimed that for a period of time the problems with a claim resulted from incorrect submissions made by the IHS, whose computer system had malfunctioned. A Medicare audit later uncovered the errors, and tribes were made to repay the overpayment claimed by the IHS system, along with penalties, even though they had no control over the submission to the Fiscal Intermediary, nor any way of determining that they had in fact received an overpayment.[1]

B. HISTORY OF THE DEMONSTRATION PROGRAM

In 1988, the Indian Health Care Improvement Act was amended. In the course of gathering information regarding the IHCIA, several tribal leaders submitted comments regarding the desire of tribes to streamline the process for billing Medicare and Medicaid reimbursements.

Specifically, Indian tribes and tribal organizations who contracted the operation and administration of IHS facilities stated that,

> . . . should they be allowed to retain all of the funds they collect from Medicaid and Medicare reimbursements and third party insurers, they could better control their own cost accounting systems and accounts receivable, and that they could thereby maximize and increase the amounts collected from such sources. Tribes and tribal organizations believe that the policy of self-determination dictates this step toward a degree of financial autonomy that will better equip them to one day assume the full range of responsibilities that are associated with the provision of health care. Evidence submitted by tribal contractors in Alaska would indicate that because of certain legal impediments that exist to the collection of third party resources by the Indian Health Service, tribal contractors can in fact collect amounts from third party sources far in excess of the amounts that Indian Health Service is able to collect.—S. Rep. 100–508, 100th Cong., 2nd Sess. 1988, 1988 U.S.C.C.A.N. 6183, 1988 WL 169927.

The Committee, in its report to the Senate, stated its intention to review the effectiveness of the demonstration program after several years in order to make an informed decision as to whether to continue the program and offer it to additional participants. S. Rep. 100–508, 100th Cong., 2nd Sess. 1988, 1988 U.S.C.C.A.N. 6183, 1988 WL 169927.

In 1996, Congress, based on evidence presented to it regarding the success of the Demonstration Program, extended the Demonstration Program for two more years to allow time for the DHHS to make its report to Congress. The program was extended again in 1998, based upon a favorable report made to Congress by DHHS.

[1] See Department of Health and Human Services, Report to Congress on the Tribal Demonstration Program on Direct Billing for Medicare, Medicaid and Other Third Party Payors, Appendix D, December 15, 1998.

C. DEMONSTRATION PROGRAM RESULTS

Four facilities were chosen to participate in the Demonstration Program: the Southeast Alaska Regional Health Consortium ("SEARHC"), Sitka, Alaska; the Bristol Bay Area Health Corporation, Dillingham, Alaska; the Choctaw Nation of Oklahoma, Durant Oklahoma; and the Mississippi Band of Choctaw Indians, Philadelphia, Mississippi.

Under the terms of the Demonstration Program, the participants were authorized to make claims directly to the Fiscal Intermediary for reimbursement. In order to become a participant, the tribe's facility had to meet IHS requirements for operation of its own programs and the facility needed to be accredited by an accrediting body designated by the Secretary—the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").

All funds reimbursed were required to be used for specific purposes. The first priority for the funds received was to make improvements within the facility which would allow it to maintain compliance with the conditions and requirements applicable generally to all facilities under Medicare and Medicaid programs (to continue to be accredited by the accrediting body). If funds remained after compliance was maintained, the excess was to be used only to improve the health resources available to the Indian tribe. All funds were to be expended in accordance with IHS regulations applicable to funds provided by the IHS under a contract entered into under the Indian Self-Determination Act (25 U.S.C. 450f et seq.).

The Medicare and Medicaid Direct Billing Demonstration Program was, by all accounts, a success. The Department of Health and Human Services, in a report delivered to Congress in December of 1998, stated that the "demonstration project has been a success as it has simplified, streamlined, and increased collections." The DHHS reported that the direct billing process had four positive effects for the four participating tribes.

Medicare and Medicaid collections increased dramatically at all four facilities. The increase in collections for both Medicaid and Medicare combined ranged from 152% at the SEARHC facility to 364% at the Bristol Bay facility.

The increased collections were used by all four tribes to address compliance issues at their facilities. The body designated by the Secretary as responsible for accreditation was the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and all programs were required to meet JCAHO standards for accreditation before participating in the Demonstration Project.

During the term of the Demonstration Project, all four facilities reported increases in their status and ratings with the JCAHO and three of the projects reported significant increases in their standing with the JCAHO. SEARHC reported receiving the highest score possible. The SEARHC facility also received the highest ranking possible for the years 1996 and 1997.

Three of the four participants also reported that they expended excess funds to improve the health resources available to the tribe. Most of these funds were used to improve facilities, to acquire additional medical equipment, and to hire additional staff. The Mis-

sissippi Band of Choctaw Indians reported that additional funds were used to open three new clinics, geared toward tuberculosis, diabetes and Women's Wellness. The Choctaw Nation of Oklahoma reported program expansions at three locations, the opening of a diabetes treatment center and the use of an improved information system. The remaining participants reported that the increased collections were used to hire new staff and implement projects that both improved their JCAHO rating and improved the health resources offered by the tribe.

Finally, all projects reported a large decrease in the amount of time between billing and collection. Each tribe reported saving at least two months time, and one tribe reported saving up to eight months time between billing and collection. This was largely due to increased, direct contact with the Fiscal Intermediary. The participants reported that the direct contact with the Fiscal Intermediary allowed them to "improve billings and collection practices, improve management of accounts receivable, reduce the time between billing and collection, and improve management planning on use of collections." [2]

The Department went on to recommend that the Demonstration Program be made permanent and that the program be open to an expanded number of participants.[3]

On August 4, 1999, the Committee held a hearing to discuss the provisions of S. 406. Witnesses attending the hearing included a representative of the DHHS/IHS, Mr. Michel E. Lincoln, a participant in the pilot project, the Honorable Gregory Pyle, Chief of the Choctaw Nation of Oklahoma, Dr. Buford Rolin of the National Indian Health Board and W. Ron Allen of the National Congress of American Indians.

Every witness stated their support for the provision of S. 406. The Honorable Gregory Pyle summed it up this way, "Without question Senate Bill 406 is a win win situation for the tribes and the Indian Health Service * * * "

S. 406 creates a more efficient and effective means for the Medicare and Medicaid reimbursement to tribes. But more importantly, it is a recognition of the government to government relationship that exists between the federal government and Indian tribes, and furthers the policy of tribal self-determination by allowing tribes to best determine the allocation and use of funds received.

## LEGISLATIVE HISTORY

S. 406 was introduced on February 10, 1999, by Senator Murkowski for himself, and Senators Lott, Campbell, Inouye, Inhofe, Baucus and Cochran. Senator Hatch was added as a cosponsor on September 8, 1999. S. 406 was referred to the Committee on Indian Affairs. The bill was the subject of a hearing held by the Senate Committee on Indian Affairs on August 4, 1999. S. 406 was ordered to be reported to the full Senate on August 4, 1999.

---

[2] See Department of Health and Human Services, Report to Congress on the Tribal Demonstration Program on Direct Billing for Medicare, Medicaid and Other Third Party Payors, page 9, December 15, 1998.

[3] Department of Health and Human Services, Report to Congress on the Tribal Demonstration Program on Direct Billing for Medicare, Medicaid and Other Third Party Payors, page 10, December 15, 1998.

SECTION-BY-SECTION ANALYSIS

*Section 1. Short title*

This section contains the title of the Act as the "Alaska Native and American Indian Direct Reimbursement Act of 1999."

*Section 2. Findings*

This section authorizes the permanent establishment of the direct billing program; states the benefits of the program; states the expiration and extension dates; and gives the benefit of providing permanent status to the demonstration program.

*Section 3. Direct billing of Medicare, and other third party payors*

Subsection (a) amends Section 405 of 25 U.S.C. 1645 to provide for the permanent authorization and establishment of the direct billing program. Subsection (a) also provides for the amendments of Section 405 of IHCIA as follows.

Subsection (a)(1) authorizes tribes to directly bill for payment to be made under the Medicare program (Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)), State plans for medical assistance approved under Title XIX of the Social Security Act, and third party payors.

Subsection (a)(2) provides for direct billing from the Medicaid program (section 1905(b) of the Social Security Act, 42 U.S.C. 1396(b)).

Subsection (b)(1) describes that the funds reimbursed will first be used by the hospital or clinic for the purposes of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable to facilities of such type under the Medicare or Medicaid programs.

Subsection (b)(2) states that all tribal hospitals and clinics participating in the program shall be subject to all auditing requirements applicable to programs administered directly by the Service.

Subsection (b)(3) provides for Secretarial oversight of the program by requiring the submission of annual reports by participants of the program.

Subsection (b)(4) ensures that no payments will be made out of the special funds described in Section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) or section 402(a) of the IHCIA.

Subsection (c)(1) establishes the eligibility requirements for participation in the program.

Subsection (c)(2) sets forth the required contents of the tribal application for participation in the program; the timeline for approval by the Secretary or the submitted applications; allows for the continued, uninterrupted participation of the demonstration program participants; and states the duration of the approved application.

Subsection (d)(1) gives the authority to the Secretary for the examination of any administrative changes that may be necessary to facilitate direct billing and reimbursement.

Subsection (d)(2) sets out the reporting requirements for accounting information that a participant will have to submit to the Secretary, and provides for periodic changes in the required information.

Subsection (e) allows for a participant to withdraw from the program in the same manner that a tribe retrocedes a contracted program to the Secretary under authority of the Indian Self-Determination Act (25 U.S.C. 450 et seq.)

Subsection (b) provides for conforming amendments of this Act.

Subsection (c) states the effective date of this Act as October 1, 2000.

## COST AND BUDGETARY CONSIDERATIONS

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
*Washington, DC, August 27, 1999.*

Hon. BEN NIGHTHORSE CAMPBELL,
*Chairman, Committee on Indian Affairs,*
*U.S. Senate, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 406, the Alaska Native and American Indian Direct Reimbursement Act of 1999.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Dorothy Rosenbaum.

Sincerely,

BARRY B. ANDERSON
(For Dan L. Crippen, Director).

Enclosure.

### CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

*S. 406—Alaska Native and American Indian Direct Reimbursement Act of 1999*

Summary: S.406 would extend indefinitely an Indian Health Services (IHS) demonstration project that allows four tribally-operated IHS facilities to bill the Medicare and Medicaid programs directly, rather than submitting their claims through the IHS. The bill also would allow all other tribally-operated IHS facilities to bill Medicare and Medicaid directly. CBO estimates that the bill would raise federal outlays by $9 to $10 million in each of fiscal years 2001 to 2004. Federal Medicare outlays would be higher by about $3 million a year, and federal Medicaid outlays would be higher by about $7 million a year. Because the bill would affect direct spending, pay-as-you-go procedures would apply.

S. 406 contains no private-sector or intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). Participation in the direct billing program could improve the cash-flow of health facilities operated by tribal governments.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 406 is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

| | Outlays, by fiscal years, in million of dollars— | | | | |
|---|---|---|---|---|---|
| | 1999 | 2000 | 2001 | 2002 | 2003 |
| CHANGES IN DIRECT SPENDING | | | | | |
| Medicare | 0 | 0 | 3 | 3 | 3 | 3 |

| | Outlays, by fiscal years, in million of dollars— | | | | | |
|---|---|---|---|---|---|---|
| | 1999 | 2000 | 2001 | 2002 | 2003 | |
| Medicaid | 0 | 0 | 7 | 7 | 6 | 6 |
| Total | 0 | 0 | 10 | 10 | 9 | 9 |

Note.—Components may not sum to totals because of rounding.

Basis of estimate: Under current law, four tribally-operated Indian Health Service demonstration sites are authorized to bill the Medicare and Medicaid programs directly rather than submitting their claims through the IHS. The demonstration authority expires September 30, 2000. S. 406 would allow all tribally-operated IHS facilities to bill Medicare and Medicaid directly.

According to IHS, seven hospitals are tribally-operated and would likely choose to bill Medicare and Medicaid directly. In 1997, Medicare and Medicaid collections totaled $55 million in these facilities. In addition, more than 150 health stations, health centers, and clinics would be eligible to bill directly under the legislation. CBO assumes that all of the hospitals would choose to bill directly over the next several years but that only a few of the largest of the other facilities would develop the infrastructure necessary to adopt direct billing. CBO further assumes that a few additional hospitals would become tribally-operated and begin to bill directly.

Based on information from the IHS on the experiences in the demonstration sites, CBO assumes that direct billing would increase Medicare and Medicaid payments for two reasons. First, the demonstration sites report a reduction in the amount of time between filing reimbursement claims and receiving payment. CBO therefore assumes that in the first year a facility participated in direct billing, it would receive one to two extra months worth of Medicare and Medicaid payments. The legislation would also increase federal costs in the four existing demonstration sites because under current law they are required to return to billing Medicare and Medicaid through IHS and will therefore experience a one- to two-month slow-down in Medicare and Medicaid collections. Of the $37 million in estimated Medicare and Medicaid costs over the 2000–2004 period, $11 million is attributable to the one-time acceleration of payments.

Second, demonstration sites reported increased Medicare and Medicaid payments under direct billing because of improved claims processing. The sites reported that they were better able to track their claims and to correct errors under direct billing than when they filed their claims through the IHS. Medicare and Medicaid payments have grown dramatically in both demonstration sites and nondemonstration IHS facilities in the ten years since the demonstration was authorized. Much of the growth stems from higher Medicare and Medicaid reimbursement rates for IHS facilities, efforts by IHS to improve its Medicare and Medicaid collections, and general growth in medical costs and enrollment, rather than from direct billing. Nonetheless, based on the experience in the demonstration sites, CBO assumes that the improved claims processing procedures that direct billing enables would increase Medicare and Medicaid payments by about 10 percent in the facilities that choose to undertake it.

In addition, direct billing may slightly reduce IHS administrative costs, which are subject to annual appropriations.

Pay-as-you-go considerations: Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purpose of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

| | By fiscal years, in millions of dollars— | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
| Changes in outlays | 0 | 0 | 10 | 9 | 9 | 9 | 9 | 10 | 11 | 11 | 12 |
| Changes in receipts | Not applicable | | | | | | | | | | |

Estimated impact on state, local, and tribal governments: S. 406 contains no intergovernmental mandates as defined in UMRA. By allowing all tribally-operated IHS facilities to bill Medicare and Medicaid directly, the bill would shorten the period of time for receiving reimbursements and improve processing procedures. Medicare and Medicaid amounts supporting trial health facilities are 100-percent federally funded. The direct billing would increase the cash-flow position of facilities that chose to participate.

Estimated impact on the private sector: The bill contains no private-sector mandates as defined in UMRA.

Previous CBO estimates: In July 1998, in a letter to Senator Frank H. Murkowski, CBO estimated that extending the direct billing authority would increase Medicare and Medicaid costs by about $5 million a year. CBO relied on a similar methodology in this estimate, but the estimate now is higher for two reasons. First, in January 1999 the Department of Health and Human Services increased the rates paid to IHS facilities by an estimated 15 percent. The higher rates increase the cost of the legislation because there would be larger amounts paid to the facilities that implement direct billing. Second, a very large hospital, Alaska Native Medical Center (ANMC), whose Medicare and Medicaid collections are almost as large as the total for the other tribally-operated hospitals that do not participate in the demonstration project, has become tribally-operated since CBO completed the July 1998 estimate. In the earlier estimate CBO assumed that ANMC would become tribally-operated and participate in direct billing late in the projection period. Now CBO assumes ANMC would participate shortly after the bill becomes effective.

Estimate prepared by: Federal Costs: Dorothy Rosenbaum. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on the Private Sector: Stuart Hagen.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

## REGULATORY AND PAPERWORK IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires that each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in car-

rying out the bill. The Committee believes that S. 1770 will have minimal regulatory or paperwork impact.

## CHANGES IN EXISTING LAW

In compliance with subsection 12 of the XXVI of the Standing Rules of the Senate, the Committee states that enactment of S. 406, as amended, will result in the following changes in the following statutes as noted below. Deletions are in brackets; new material is in italic.

1. Section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645) is amended as follows:

[(a) ESTABLISHMENT.—The Secretary shall establish a demonstration program under which Indian tribes, tribal organizations, and Alaska Native health organizations, which are contracting the entire operation of an entire hospital or clinic of the Service under the authority of the Indian Self-Determination Act (25 U.S.C. 450f et seq.), shall directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (medicare), under a State plan for medical assistance approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (medicaid), or from any other third-party payor. The last sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) shall apply for purposes of the demonstration program.

[(b) DIRECT REIMBURSEMENT.—

[(1) Each hospital or clinic participating in the demonstration program described in subsection (a) of this section shall be reimbursed directly under the medicare and medicaid programs for services furnished, without regard to the provisions of section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) and sections 1642(a) and 1680c(b)(2)(A) of this title, but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under the medicare or medicaid program. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements shall be used—

[(A) solely for improving the health resources deficiency level of the Indian tribe, and

[(B) in accordance with the regulations of the Service applicable to funds provided by the Service under any contract entered into under the Indian Self-Determination Act (25 U.S.C. 450f et seq.).

[(2) The amounts paid to the hospitals and clinics participating in the demonstration program described in subsection (a) of this section shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare and medicaid programs.

[(3) The Secretary shall monitor the performance of hospitals and clinics participating in the demonstration program described in subsection (a) of this section, and shall require

such hospitals and clinics to submit reports on the program to the Secretary on a quarterly basis (or more frequently if the Secretary deems it to be necessary).

[(4) Notwithstanding section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) or section 1642(a) of this title, no payment may be made out of the special fund described in section 1880(c) of the Social Security Act, or section 1642(a) of this title, for the benefit of any hospital or clinic participating in the demonstration program described in subsection (a) of this section during the period of such participation.

[(c) REQUIREMENT FOR PARTICIPATION.—

[(1—In order to be considered for participation in the demonstration program described in subsection (a) of this section, a hospital or clinic must submit an application to the Secretary which establishes to the satisfaction of the Secretary that—

[(A) the Indian tribe, tribal organization, or Alaska Native health organization contracts the entire operation of the Service facility.

[(B) the facility is eligible to participate in the medicare and medicaid programs under sections 1880 and 1911 of the Social Security Act (42 U.S.C. 1395qq, 1396j);

[(C) the facility meets any requirements which apply to programs operated directly by the Service; and

[(D) the facility is accredited by the Joint Commission on Accreditation of Hospitals, or has submitted a plan, which has been approved by the Secretary, for achieving such accreditation prior to October 1, 1990.

[(2) From among the qualified applicants, the Secretary shall, prior to October 1, 1989, select no more than 4 facilities to participate in the demonstration program described in subsection (a) of this section. The demonstration program described in subsection (a) of this section shall begin by no later than October 1, 1991, and end on September 30, 1998.

[(d) EXAMINATION AND IMPLEMENTATION CHANGES.—

[(1) On November 23, 1998, the Secretary, acting through the Service, shall commence an examination of—

[(A) any administrative changes which may be necessary to allow direct billing and reimbursement under the demonstration program described in subsection (a) of this section, including any agreements with States which may be necessary to provide for such direct billing under the medicaid program; and

[(B) any changes which may be necessary to enable participants in such demonstration program to provide to the Service medical records information on patients served under such demonstration program which is consistent with the medical records information system of the Service.

[(2) Prior to the commencement of the demonstration program described in subsection (a) of this section, the Secretary shall implement all changes required as a result of the examinations conducted under paragraph (1).

[(3) Prior to October 1, 1990, the Secretary shall determine any accounting information which a participant in the dem-

onstration program described in subsection (a) of this section would be required to report.

[(e) REPORT.—The Secretary shall submit a final report at the end of fiscal year 1996, on the activities carried out under the demonstration program described in subsection (a) of this section which shall include an evaluation of whether such activities have fulfilled the objectives of such program. In such report the Secretary shall provide a recommendation, based upon the results of such demonstration program, as to whether direct billing of, and reimbursement by, the medicare and medicaid programs and other third-party payors should be authorized for all Indian tribes and Alaska Native health organizations which are contracting the entire operation of a facility of the Service.

[(f) RETROCESSION OF CONTRACT.—The Secretary shall provide for the retrocession of any contract entered into between a participant in the demonstration program described in subsection (a) of this section and the Service under the authority of the Indian Self-Determination Act (25 U.S.C. 450f *et seq.*). All cost accounting and billing authority shall be retroceded to the Secretary upon the Secretary's acceptance of a retroceded contract.]

*(a) ESTABLISHMENT OF DIRECT BILLING PROGRAM.—*

*(1) IN GENERAL.—The Secretary shall establish a program under which Indian tribes, tribal organizations, and Alaska Native health organizations that contract or compact for the operation of a hospital or clinic of the Service under the Indian Self-Determination and Education Assistance Act may elect to directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (in this section referred to as the "medicare program"), under a State plan for medical assistance approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (in this section referred to as the "medical program"), or from any other third party payor.*

*(2) APPLICATION OF 100 PERCENT FMAP.—The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) shall apply for purposes of reimbursement under the medicaid program for health care services directly billed under the program established under this section.*

*(b) DIRECT REIMBURSEMENT.—*

*(1) USE OF FUNDS.—Each hospital or clinic participating in the program described in subsection (a) of this section shall be reimbursed directly under the medicare and medicaid programs for services furnished, without regard to the provisions of section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) and sections 402(a) and 813(b)(2)(A), but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under the medicare or medicaid programs. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions shall be used—*

*(A) solely for improving the health resources deficiency level of the Indian tribe; and*

*(B) in accordance with the regulations of the Service applicable to funds provided by the Service under any contract entered into under the Indian Self-Determination Act (25 U.S.C. 450f et seq.).*

*(2) AUDITS.—The amounts paid to the hospitals and clinics participating in the program established under this section shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare and medicaid programs.*

*(3) SECRETARIAL OVERSIGHT.—Any participant in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 1999 shall only be required to submit annual reports under this paragraph.*

*(4) NO PAYMENTS FROM SPECIAL FUNDS.—Notwithstanding section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) or section 402(a), no payment may be made out of the special funds described in such sections for the benefit of any hospital or clinic during the period that the hospital or clinic participates in the program established under this section.*

*(c) REQUIREMENTS FOR PARTICIPATION.—*

*(1) APPLICATION.—Except as provided in paragraph (2)(B), in order to be eligible for participation in the program established under this section, an Indian tribe, tribal organization, or Alaska Native health organization shall submit an application to the Secretary that establishes to the satisfaction of the Secretary that—*

*(A) the Indian tribe, tribal organization, or Alaska Native health organization contracts or compacts for the operation of a facility of the Service;*

*(B) the facility is eligible to participate in the medicare or medicaid programs under section 1880 or 1911 of the Social Security Act (42 U.S.C. 1395qq; 1396j);*

*(C) the facility meets the requirements that apply to programs operated directly by the Service; and*

*(D) the facility is accredited by an accrediting body designated by the Secretary or has submitted a plan, which has been approved by the Secretary, for achieving such accreditation.*

*(2) APPROVAL.—*

*(A) IN GENERAL.—The Secretary shall review and approve a qualified application not later than 90 days after the date the application is submitted to the Secretary unless the Secretary determines that any of the criteria set forth in paragraph (1) are not met.*

*(B) GRANDFATHER OF DEMONSTRATION PROGRAM PARTICIPANTS.—Any participant in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 1999 shall be deemed approved for participation in the program established*

*under this section and shall not be required to submit an application in order to participate in the program.*

*(C) DURATION.—an approval by the Secretary of a qualified application under subparagraph (A), or a deemed approval of a demonstration program under subparagraph (B), shall continue in effect as long as the approved applicant or the deemed approved demonstration program meets the requirements of this section.*

*(d) EXAMINATION AND IMPLEMENTATION OF CHANGES.—*

*(1) IN GENERAL.—The Secretary, acting through the Service, and with the assistance of the Administrator of the Health Care Financing Administration, shall examine on an ongoing basis and implement—*

*(A) any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this section, including any agreements with States that may be necessary to provide for direct billing under the medicaid program; and*

*(B) any changes that may be necessary to enable participants in the program established under this section to provide to the Service medical records information on patients served under the program that is consistent with the medical records information system of the Service.*

*(2) ACCOUNTING INFORMATION.—The accounting information that a participant in the program established under this section shall be required toreport shall be the same as the information required to be reported by participants in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 1999. The Secretary may from time to time, after consultation with the program participants, change the accounting information submission requirements.*

*(e) WITHDRAWL FROM PROGRAM.—A participant in the program established under this section may withdraw from participation in the same manner and under the same conditions that a tribe or tribal organization may retrocede a contracted program to the Secretary under authority of the Indian Self-Determination Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this section shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.*

2. Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended by adding at the end the following:

*(e) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).*

3. Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended by adding at the end the following:

*(d) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations*

*to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act (25 U.S.c. 1645).*

○